breast milk, fruit, and vegetables; a far cry from the stereotype of the starchy low-protein diet.) This example of three children consuming essentially the same foods, but developing clinical signs which span the whole range of marasmus-kwashiorkor, will encourage those workers who look for factors other than specific dietary deficiencies to account for the different types of protein-energy malnutrition.

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¹ Eddy, T P, *Tropical Doctor*, January 1977, 28.

² Waterlow, J C, and Payne, P R, *Nature*, 1975, **258**, 113.

³ Gopalan, C, in *Calorie Deficiencies and Protein Deficiencies*, ed R A McCance and E M Widdowson. London, Churchill, 1968.

SIR,—We were interested to read the excellent article by Dr I F Roberts and others (3 February, p 296) on the effect of cult diets on children, such as the Zen macrobiotic diets.

Zen is a form of religion where great emphasis is placed on meditation, as opposed to theology. This meditation is an alteration to a trance-like state of consciousness caused by practised underbreathing while thinking of a repetitive phrase (mantra). Studies have shown that various physiological and biochemical changes take place during meditation. For example, Wallace¹ showed decreased oxygen uptake during meditation; Jevning² showed an increase in serum prolactin and serum phenylalanine concentrations; while other workers have shown an increased urinary output of 5-hydroxy indoleacetic acid and a decreased output of urinary vanilmandelic acid.³ This suggests that a decrease of brain sympathomimetic amines and a flush of serotonin occurs.⁴ The ancient Vedic writings of India gave explicit rules on food designed for a peaceful meditation, but not for children's nutrition. Thus they forbid foods rich in tyramine, such as fermented cheese, wine, and other fermented drinks. Tyrosine- and phenylalanine-containing foods are to be avoided (for example, meat). Tyrosine, tyramine, and phenylalanine are converted to sympathomimetic amines. It is possible that the extra sympathomimetic amines cause a very "bumpy" meditation. Many meditators who stick to a strict diet complain bitterly and are excessively irritated if they transgress the rigid diet. We believe that the diet was not designed for children.

We wonder also if the parents of these children had difficulty in conceiving while they were meditating regularly, as we have noticed a significant difference in the sex-hormone-binding globulin (SHBG) in such people compared with age-matched normal controls (see table)—the meditators had similar SHBG concentrations to those found

in a sample of six impotent men. The meditators also had a significantly low testosterone:SHBG ratio compared with controls and thus less free testosterone.

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¹ Wallace, R K, *Scientific Research on the Transcendental Meditation Programme*: PhD thesis, 1970.

² Jevning, R, Abstract of the Psychophysiological Society's 57th annual meeting, New York City, June 1975, p 257.

³ Jevning, R, in *Scientific Research on the Transcendental Meditation Programme: Collected Papers*, vol 1, ed D W Orme-Johnson and J T Farrow, p 145. Seelischberg, Maharishi European Research University Press, 1976.

⁴ Bujatti, M, *et al*, *Journal of Neurological Transmission*, 1976, **39**, 257.

The Queensland Melanoma Project

SIR,—The impressively high five-year survival rate obtained for patients with primary malignant melanoma in Queensland was the subject of a recent article by Dr Tony Smith (27 January, p 253). It has been claimed¹ that this is the result of heightened public awareness of the disease and its consequent earlier diagnosis and treatment, and Dr Smith discusses the wider implications of sustained public and professional education, suggesting that a similar approach be adopted to other diseases where delayed treatment might adversely affect the outcome.

So far as melanoma is concerned, however, the data do not convince. Primary cutaneous melanomas arise in the junctional layer and ultimately penetrate down into the deeper structures of the skin, acquiring metastatic potential when the capillaries or lymphatics of the reticular dermis are invaded. Tumours confined to the more superficial papillary dermis, however, carry a much better prognosis.²⁻³ The results obtained from the Queensland Melanoma Project, which Dr Smith quotes, show that, out of 1187 patients with cutaneous melanoma, no fewer than 757 (63%) had primaries invading the reticular dermis (Clark's level 4), whereas only 417 (35%) had more superficial lesions. In contrast, Clark *et al*³ found that 37% of patients attending the Massachusetts General Hospital had melanomas penetrating to level 4 compared with 51% where the tumour was confined to the papillary dermis; and very similar figures were obtained at the Memorial Hospital by Wanebo *et al*³ in a later study. The numbers of patients with tumours invading subcutaneous fat (Clark's level 5), the least favourable microscopical stage, were similar in all three series. At the time of excision, then, primary melanomas tend to be more advanced, biologically if not chrono-

logically, in Queensland than they are in the Eastern United States, yet despite this Queenslanders have the better overall prognosis.

A possible explanation might be that the natural history of the disease is different in the two countries. For a given depth of dermal invasion the incidence of lymph node metastases found at the time of elective block dissection appears to be less in Queensland. Thus Little⁴ found a 15% incidence in primaries invading the reticular dermis as against 25% in Wanebo's series. Where the subcutaneous fat was invaded the difference was even greater—34% versus 70%. If these differences are real they would imply that the better prognosis for primary melanoma in Queensland is in some way related to its lower metastatic potential. I suggest that before these results are cited to justify further health education schemes the possibility that the Queensland success is due to a high incidence of relatively indolent tumours be considered.

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¹ Beardmore, G L, *International Journal of Dermatology*, 1977, **16**, 831.

² Clark, W H, *et al*, *Cancer Research*, 1969, **29**, 705.

³ Wanebo, H J, Woodruff, J, and Fortner, J G, *Cancer*, 1975, **35**, 666.

⁴ Little, J H, *Progress in Clinical Cancer*, 1975, **6**, 163.

Are they being served?

SIR,—I was very glad to see your recent leading article on the importance of the Chronically Sick and Disabled Persons Act (20 January, p 147).

As you point out, general practitioners are busy people. Some may well feel they have enough to do without involving themselves in socioeconomic problems that go beyond their immediate concern. Yet, as you recognise, the GP is often the first point of contact for the severely disabled person, and the doctor is therefore particularly well placed to alert him to a whole range of services and cash benefits which, if he only knew about them, could much improve the quality of his life. In support of the approach taken by your leading article, I should thus like to make a bid for the severely disabled patient to be regarded by the GP as a special case. My aim in so doing is to achieve better communication with the disabled for the purpose of making sure they receive all the help that recent legislation makes available to them.

My department has been giving a great deal of thought to ways of improving take-up of benefits and I am at present studying possible means of ensuring the supply of a better range of posters and pamphlets, including their availability in doctors' waiting rooms. We are in touch with a number of leading voluntary organisations about this. I hope that they, like me, will regard this whole question of information giving as a matter of prime importance. Your help in bringing the matter to the attention of the medical profession will be very widely appreciated.

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SIR,—I read with interest your leading article entitled "Are they being served?" (20 January,

Differences in sex-hormone-binding globulin (SHBG) and testosterone:SHBG ratio in meditators, controls, and impotent men

	No	SHBG*		Probability (t test)	Testosterone:SHBG ratio		Probability (t test)
		Mean	SD		Mean	SD	
Meditating men	7	38.71 ± 15.2	}	<0.05	0.6315 ± 0.258	}	<0.05
Matched controls	16	24.18 ± 4.92			1.058 ± 0.396		
Impotent men	6	38.75 ± 7.62					

*Measured as nmol/l binding capacity of dihydroxytestosterone.

p 147). While I welcome the intention of the article in drawing attention to the patchy and faltering implementation of the 1970 Chronically Sick and Disabled Persons Act in many parts of Great Britain, I am astounded at the lack of discussion of the real progress that has been made by OUTSET, among others, in producing and testing efficient methods of identifying the "hidden handicapped" in the community. Your editorial asks, "How can we find the 'hidden handicapped'?" and suggests a number of methods, many of which have been looked into and shown to be inadequate. The only method found by us to be reliable is to find out by door-to-door survey where handicapped people are, and follow this up with an in-depth interview of each handicapped person identified in order to ascertain difficulties and requirements.

OUTSET has been involved in over 20 surveys of this nature since the passing of the 1970 Act, and more recently has been able to improve techniques substantially by marrying our survey methods to the classification of handicap pioneered by Dr Margaret Agerholm. We have found that our techniques produce a variety of useful information, as well as putting individual handicapped people in touch with relevant services. Currently, we are carrying out, among other projects, a major survey of the whole of Northern Ireland, aiming to obtain a response from each household in the province, and to interview 50 000-70 000 handicapped people thus discovered.

I would have thought that the already encouraging success of this venture is in itself a worthy answer to your question. It is with sadness therefore that I observe your reluctance to recommend or indeed mention it.

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Acute poisoning with Distalgesic

SIR,—So Dr J A J H Critchley and others (3 February, p 342) wish to start a nationwide campaign on the use and restriction of Distalgesic. Is this not the tail wagging the dog? At least with the campaign on barbiturates, effective and safer alternatives were available. Distalgesic is widely and correctly used by vast numbers of patients, particularly with rheumatic diseases. I would estimate some 40% of my patients have taken Distalgesic at some stage: I am unaware of any patient who was unable to give up Distalgesic when the clinical condition had improved and I am unaware of any patient who has become addicted to it. I do not consider that continuing Distalgesic in the medication of an ongoing painful condition is addiction. No patient of mine has yet taken an overdose. Although there may not be adequate double-blind controlled trials proving that Distalgesic is superior to other analgesics, most of the patients who remain on Distalgesic infinitely prefer it to the other analgesic drugs they have tried and that seems a reasonable basis on which to continue prescribing Distalgesic.

Perhaps those who feel strongly about drug abuse (and I have sympathy with their view) should devote their missionary zeal to changing the nature of man or the world, as curbing the use of Distalgesic will merely transfer drug abuse to another easily available drug, as happened when phenacetin was removed from aspirin, phenacetin, and codeine tablets.

The incidence of suicide has not greatly changed since coal gas was withdrawn: people merely use different agents. On epidemiological grounds I wonder whether Dr Critchley *et al* are correct. Distalgesic is very widely prescribed and the admission of 130 cases of self-poisoning in a year may only reflect the frequency with which Distalgesic is prescribed, rather than suggesting that it is the most popular drug for drug abuse.

It is remarkable how just a little abuse by a few can affect thousands of satisfied users—as in the case of the paternoster lift at Northwick Park, which has been out of use for six months as a result of being abused by a skylarking juvenile (delinquent) unconnected with the hospital. Many have suffered gross inconvenience meanwhile.

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Storage and cooking of poultry

SIR,—Readers who consulted your leading article (18 November, p 1385) on the storage and cooking of poultry will have had a Merry Christmas and escaped a food-poisoning infection. In order to do so, however, they must have risen inordinately early on Christmas Day. Your advice to cook a large turkey of, say, 20 lb weight for 30 minutes per lb at 200°C (400°F) in a preheated oven implies a cooking time of 10 hours. At this temperature the bird would be well cooked—some might claim too well cooked, but at least it would be safe.

Those who do not read your journal or were too lazy to get up early on Christmas morn could follow the advice of the British Turkey Federation, circulated by the DHSS in HN(77)190, and lie in bed with a clear conscience. Their bird of the same weight required only 10½ minutes per lb at 177°C (350°F)—a total cooking time of only 3½ hours and at 23°C lower temperature.

Those of us who are asked to give advice find it difficult to reconcile these two statements. Infections due to salmonella and *Clostridium perfringens* continue to be associated with the eating of turkeys. We need evidence to support one or other of these authorities. Is such evidence available?

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How to use a library

SIR,—Medical librarians are nearly always pleased at any attempt to publicise the collections in their care, or the services they try to offer; and most of us these days can do with all the help we can get—but some of us will have read Dr M G Timbury's article (27 January, p 252) with some disappointment. Although I realise that this presented the views of one departmental librarian, and that it did contain some useful information, the role of the medical librarian was dealt with in four lines.

The task of carrying out detailed searches of an ever-expanding literature, with all its complexities, is one many of us would regard as

something only trained, skilled, and experienced librarians can do. This is not to say that readers cannot often help themselves; but medical librarians are in a special position because, unlike doctors, they are able to concentrate on the literature "for itself alone" and are not directly concerned with its implementation—in other words, they are able to act as a bridge between the literature and the reader.

Librarians are used to being a somewhat misunderstood profession and are accustomed, on the one hand, to having effusive praise for merely telling a reader where the *BMJ* is located and, on the other hand, to meeting a lack of understanding of the many techniques and often considerable experience involved in dealing with highly complex bibliographical inquiries. Nevertheless, some readers in the past have recognised the role we play; and in 1953 Sir Cecil Wakeley, the president of the First International Congress on Medical Librarianship, reminded us that "some of the finest consultants available are to be found in medical libraries"—meaning medical librarians. Many of us would be quite content to accept this evaluation of our work.

In recent years some valuable papers by medical librarians have appeared, and one could cite the excellent series by Miss F M Picken.^{1,2} I do not wish to comment on Dr Timbury's recommendations or the references she gives in further detail but I was surprised that, although she cited Mr L T Morton's *Use of Medical Literature*, 2nd edition, 1977, she did not refer to the other book by one of our most distinguished medical librarians—*How to Use a Medical Library*,³ which first appeared in 1934.

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¹ Picken, F M, *Teach-In*, 1974, 3, 302, 237, 297, 427, and 506.

² Picken, F M, *Hospital Update*, 1975, 1, 59 and 563.

³ Morton, L T, *How to Use a Medical Library*, 6th edn. London, Heinemann, in press.

SIR,—I read with interest the excellent article by Dr Morag Timbury on "How to use a library" (27 January, p 252). As she points out, she has presented her own viewpoint, but has nevertheless covered sufficient points to provide an adequate introduction to library use.

Might I, however, elaborate on just a few of her points? *Index Medicus* is all Dr Timbury says it is—but it is also something more. For the last few years it has included a selection of monographs—mostly conference proceedings and the like, listing the individual papers by author and subject. For those who may wish to know whether a particular conference has reached publication, there is a useful publication called *Directory of Published Proceedings: Series SEMT* (science, engineering, medicine, and technology). The National Library of Medicine *Current Catalog* is indeed a useful bibliography. I have found that its greatest asset is its listing of US Government publications.

With regard to Medline, Dr Timbury suggests that most main libraries have direct access to the computer. There are many which do not. But even the smallest medical libraries usually have access to the postal service of Medlars, which, although somewhat slower, is preferable on occasion to manual searching. Perhaps it should be mentioned that computer searches are an expensive pastime and should be reserved for the more complicated searches.